Here is a snapshot of treatments that will be changing in the new 2001 CDC Guidelines for the Treatment of Sexually Transmitted Diseases. The Communicable Disease section does not know when the 2001 CDC Guidelines will be released, but when we receive notification we will post it on the Public Health web page. The following information came from Medscape web site: **www.medscape.com**.

Upcoming STD Treatment Guidelines From the Centers for Disease Control and Prevention (CDC)

Dr. Kim Workowski[1] of the CDC presented an overview of some of the new recommendations that will appear in the 2001 update of the CDC Guidelines for the Treatment of Sexually Transmitted Diseases. Past versions of these guidelines (current version 1998) provide important sources of clinical information and guidance for management of STDs. The new guidelines were developed using a systematic review of literature that was published over the past 4 years, internal evidence rating by CDC staff, and the opinions of external consultants. In her overview, Dr. Workowski outlined updates on specific antimicrobials used to treat a variety of STDs and screening recommendations. The new 2001 guidelines should be made available later this year.

Chlamydia

The recommended treatment regimens for chlamydial infections will now include levofloxacin 500 mg orally once daily for 7 days as an option, given that this agent has largely supplanted ofloxacin in the United States. Recent studies have emphasized that a prior chlamydial infection is a potent risk factor for repeated chlamydial infection in the ensuing 3-4 months, as is another STD such as gonorrhea or trichomoniasis. The guidelines will urge clinicians to consider rescreening at 3-4 months regardless of symptoms in order to detect and treat these repeated infections. The guidelines will continue to emphasize annual screening for chlamydial infection in sexually active adolescents and in persons aged 20-25 years. Azithromycin 1 g orally as a single dose is a well-accepted and convenient therapy for uncomplicated chlamydial infections, but data regarding its use in pregnancy are still scant.

Gonorrhea

The range of options for single-dose treatment of gonorrhea will now include levofloxacin 250 mg orally as a single dose. However, note was made of the increasing prevalence of fluoroquinolone-resistant *Neisseria gonorrhoeae* in patients with gonorrhea in Asia, Hawaii, and the Pacific region. Fluoroquinolone use for treatment is discouraged in patients with gonorrhea recently acquired from these regions. Use of single-dose oral cefixime or ceftriaxone intramuscularly is suggested in these cases.

Syphilis

Updated alternatives to benzathine penicillin for treatment of early syphilis in nonpregnant patients were presented. These included azithromycin 2 g orally as a single dose, ceftriaxone 1 g intramuscularly (IM) once daily for 10 days, or doxycycline 100 mg orally twice daily for 14 days. It is important to recognize that data to support alternatives to penicillin-based syphilis therapies are limited, and that careful follow-up of patients treated with these alternative regimens is needed. For neurosyphilis, ceftriaxone 2g

intravenously (IV) daily for 10-14 days will be suggested as an alternative to high-dose parenteral penicillin preparations.

Pelvic Inflammatory Disease (PID)

The clinical diagnosis of PID is often difficult. The new guidelines will specify the updated criteria for the clinical diagnosis of PID. According to the previous (1998) guidelines, empiric antibiotic treatment for PID should be initiated in a sexually active young woman at risk for STDs if all of the minimum criteria of *lower abdominal tenderness, adnexal tenderness* and *cervical motion tenderness* are present and no other cause for the illness can be identified.

According to the revised criteria, a sexually active young woman at risk for STDs should receive empiric antibiotic therapy for PID if all of the minimum criteria of *cervical motion tenderness*, *uterine tenderness*, and *adnexal tenderness* are present, along with *inflammatory cells (WBCs) on saline microscopy of vaginal secretions*, and if no other cause for the illness can be identified. The inclusion of a positive saline microscopy of vaginal secretions as a criterion stems from the recognition that the occurrence of PID is unlikely without the presence of vaginal discharge containing WBCs.

Levofloxacin 500 mg orally once daily for 14 days will be listed as an oral treatment regimen, with or without metronidazole 500 mg orally twice daily for 14 days. Clinical trials have supported the use of ofloxacin or levofloxacin alone in the treatment of PID when hospitalization is not required and oral therapy is appropriate.

Human Papillomavirus (HPV)

Podophyllin will no longer be recommended as a treatment option for condyloma acuminata because of toxicity and limited efficacy. More effective alternatives include imiquimod and podofilox, as well as the traditional cryotherapy or excision. Expanded counseling messages to emphasize the high prevalence of HPV infections in sexually active populations, and the variable incubation periods, will be included.

Bacterial Vaginosis (BV)

Updated recommendations will be made regarding screening and treatment of BV. Previous guidelines focused on diagnosis and treatment of symptomatic women, regardless of pregnancy status. Because of the demonstrated increased risk for postoperative infection following hysterectomy and surgical abortion in women with BV, screening for BV will be recommended together with treatment if found prior to these procedures.

Treatment is recommended for symptomatic pregnant women. Since there are few data regarding use of topical creams or gels in pregnant women, oral preparations should be used. Either metronidazole 250 mg orally 3 times daily for 7 days or clindamycin 300 mg orally twice daily for 7 days is suggested.

Adverse pregnancy outcomes, including premature rupture of membranes, preterm labor, and preterm birth, have been associated with the presence of BV during pregnancy. In women who are at high risk (ie, those who have previously delivered a premature infant), it has been suggested that screening for and treatment of BV may reduce the risk of pregnancy complications. However, results of recent clinical trials examining this question have been conflicting, and screening for BV in these settings will be left to the discretion of the practitioner pending more definitive data.

Other STDs

Other updates will include recommendations regarding the use of herpes simplex virus (HSV) type-specific serologic tests, HSV treatment and suppressive regimens for patients with HIV infections, as well as use of systemic ivermectin for severe (Norwegian) scabies infestations. Revised recommendations regarding hepatitis A and B, and inclusion of information related to hepatitis C, will also be available.